

## UK Doctors united

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# UK Doctors United

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## Introduction

Readers of Family Practice are perhaps interested in some reflections on English general practice after the first authors' three years there. As a Dutch GP with almost thirty years of experience, HvM expected to step into the birthplace of General Practice, into what he had hoped would be an even more connected, controlled and community-based version of medicine. The opposite seems true, unfortunately. Fragmentation looms, as connections are harder to find. In these three years, he asked himself why he had never observed a similar sense of crisis in general practice in the Netherlands. What could have gone wrong in the UK? We are genuinely worried about the 'sinking' of the NHS flagship, general practice, and we are not alone (1-3). In this paper, we support our experiences with a scoping review of the pertinent literature based on two systematic reviews,(5, 6), and on mostly qualitative literature (7, 8). WSS practised as a GP in Sussex for over 30 years and is a Senior Clinical Teaching Fellow at Brighton & Sussex Medical School. He is the Programme Director for Physician Associate Studies.

To illustrate the point of apparent 'disconnectedness' in general practice, one of the first patients to consult with HvM about his 'tiredness' was a 57 years old man, a smoker, who had suffered a myocardial infarction seven years ago. He was concerned about a recurrence even though he had no chest pain and no abnormalities were found on physical examination. Since the patient and HvM had no prior clinical contact together, he (quite understandably) did not have much trust in HvM. In addition, there were also obviously different backgrounds. To reassure him some tests were ordered. HvM coded the encounter with the Read code for 'tiredness'. All tests turned out to be normal. Subsequently two Accident and

Emergency room and two extra practice visits later (without abnormalities), he saw a nurse practitioner who prescribed antibiotics for influenza. So this is how discontinuation and fragmentation win, and how the core value, connectedness through continuity was lost before a working relationship with this patient even began (3). Some would point to the 2004 GP contract as the starting point, which ultimately prioritized speed of access over continuity of care. Patients were no longer registered with an individual GP, but with a GP practice (10). This may be seen as a retrograde decision in care provision.

## **Difficulties**

Generalists such as GPs and their patients face at least five difficulties in making decisions. The *first is how to connect*, to weave common ground towards shared decision making, to build trust, to adapt, and to normalise if appropriate (11, 12). GPs are often faced by diagnostic ambiguity, are required to help patients to deal with their own uncertainties, and the solution may appear through subsequent consultations (13). This is a fundamentally juxtaposed co-design dimension to the conventional hospital approach. GPs tolerate more uncertainty and ambiguity. To switch between these two approaches to dealing with uncertainty can be confusing for both the GP and the patient (and the hospital).(14) Connected generalism is under threat, because we confuse care and treatment. We overrate 'interventions' and neglect care. Atul Gawande, a professor of surgery at Harvard, describes what it was like for his father, a urologist, to grow old and die in his excellent book 'Being Mortal'(15). He explains how medicine has changed in its total focus to control death and how it has not changed over time because we still die. We have become profoundly detached from the reality of being mortal, even as medical advances

push the boundaries of survival further each year. His message is that a good and shared 'contextual' life, and not a good death, should be the goal. We need dialogue to create meaning and context and to inform decisions.

Specialist training for general practice, at least in the Netherlands, is therefore focused on experience-based learning, probably more so than in England. This type of learning supports honing dialogue skills, tolerating uncertainty and co-constructing 'sufficing' explanations. Dutch GPs furthermore have their own guidelines, such as about the management of medically unexplained physical symptoms, whereas English GPs need to follow possibly overly detailed NICE guidance. The Dutch College of General Practitioners has since 1989 drawn up its own guidelines on how to treat specific conditions in primary care. It started with diabetes and now has guidelines on around 100 conditions (16).

The second difficulty is to *detect or exclude actual 'disease'* in the 9.22 minutes available. The low prevalence of new pathology, the chronicity of existing diseases and the high co-morbidity dictate that GPs rely more on dialogue skills, contextual experience and broad 'tools' to connect: they cannot exclude all possible pathology in the perspective of 'understanding as an individual achievement' that the German philosopher of science Gadamer describes.(17) Ten percent more consultations per patient per year in the last ten years combined with a disproportionate rise in the more complicated issues that elderly people and infants present add to such pressures (18).

**Gadamer** sees a fundamental difference between 'understanding as an individual achievement' and 'understanding as an interactive process or dialogue' ('hermeneutics'). He sees two separate views about the nature of human needs. He describes in 'Truth and Method' the theory and methodology of interpretation, which was initially applied to the interpretation of scripture.(4)

In understanding as an individual achievement, the needs of the other can be uncovered through a skillful act by an interpreter, a scan, for instance. They are seen as given. An interpreter (a doctor) can fully discover the needs of the other person, in principle. This individual understanding means that total knowledge of the other is (ideally) possible, as in a full-body scan: 'This is what is wrong with you.' Care is regarded as a skilful comportment by the care-giver, based upon intuitive insight into the needs of the care-receiver. This is the interpretative model of the doctor-patient relationship. It does not require connections. An increasingly fragmented and technological medicine focuses on this first type of understanding.

In hermeneutic understanding however, the needs of the other are not seen as given, but are seen as an interactive process. Primary care doctors use this more deliberative model to help patients to make sense of uncertainty and meaning, together.(9) Care is regarded as a mutual endeavour, based upon openness and dialogue. Dialogue takes time and conscious effort to develop though.

The current fragmentation means, for instance, that it is often difficult to find the time as a UK GP, to discuss important medical decisions with patients uninterrupted, with enough time to connect with them. Quality and Outcomes Framework alerts pop up all the time on the screen to distract.

The *third difficulty* about making decisions in primary care, is that GPs want to act as gatekeepers, but that patients are not spineless objects accidentally entering the doctor's office. They can be a confusing mix of 'visitors', 'complainants' and actual 'customers'. Such gatekeeping requires time and trust: only customers buy the GP's core product i.e. their advice or explanations. The patient in the case did not buy it! To carefully explain to a tired patient how he can deal with his health anxiety quickly, takes another 9.22 minutes. If we can somehow still organize the helpful continuity of care that our frequently multi-morbid population needs, then this can save us from fragmentation, even if we have short consultations.(19)

The *fourth difficulty relates to coding*. This might seem a minor and perhaps academic issue, but it is our firm conviction that a medical 'language' has major consequences for connections. The (UK) Read code 'tiredness' was meant as an International Classification of Primary Care code (ICPC, A04). It reflected a clinical judgment that there was no immediate need to think of other clinical issues. In the terminology of the ICPC, the system that HvM worked with in the Netherlands, 'tiredness' was the clinical working hypothesis that the patient and he had discussed. ICPC is widely used in over 20 countries.(20, 21) ICPC 'tiredness' only becomes a serious illness in less than 2% of cases, and mostly progresses into depression and seldom into other conditions.(22-24) Medical languages, through their application in the process of diagnosis, attempt to 'fixate' a certain medical reality.

The traditional pathology-based coding model encountered major problems when it came to be applied to primary care in the middle of the 20th century. The low baseline risk of serious illness and the benign prognosis in community settings (provided there is a tight follow-up), required a more symptoms-based approach.

Pathology-based thinking might be helpful with a highly selected patient population and access to comprehensive diagnostic aids, in hospital practice. Most GPs find such classifications particularly unhelpful, however, in their job to 'marry the rawness of undifferentiated human illness and distress, with further actions and with actual classifiable disease (and the transitions between them)' (25). As ICPC is not used in the UK, however, this choice may fundamentally disenfranchise UK GPs' take on the clinical dialogue (20). It reflects a fundamental disregard of generalism and an unbalance in medical power towards 'partialisation.' Where 90% of contacts are dealt with in primary care for less than 8% of the healthcare budget, we worry that this choice mirrors that general practice is undervalued in the country that invented it. The dire position of medical generalism in the UK is not new, by the way. In 1850, the Colleges of Surgeons and Physicians obstructed the development of what became the College of General Practitioners only a century later.(26)

*A fifth difficulty is a major workforce crisis* (6, 27, 28). Only 19% of medical students want to work as a GP (29). One theme behind that crisis is a lack of inter-professional medical solidarity, but moreover medical autonomy is also under threat with the profession's 150 year old collegial model of self-regulation ending in the 1990s(30). There is furthermore a lack of respect for GPs among both doctors and the public (31). 'Vocational professionalism' may also be less on vogue (32), with young doctors seeking a good work-life balance, and there may be underfunding, with £134 median annual primary medical care funding per patient, minus prescription and dispensing costs (33). Added to this mix is consumerism, accountability, transparency and risk awareness (34) (35).



## **Conclusion**

Our overall analysis and heartfelt wish are that we figure out how to support GPs in the UK: how to put them in the drivers' seat of healthcare again, as they seem to be more so in the Netherlands. How we can help the English 'choir of medicine' to start singing from the same hymn sheet again? Family practice needs broad support from fellow doctors. It saddens us to see that contextual generalism is under threat. Much of what family practitioners (and other doctors) do is not pathology-based. It is about discussing, sharing, acknowledging, normalising, investigating and following-up of 'symptoms,' worries, not of 'disorders,' but it can only work when it is backed up by the rest of medicine (and society). Symptoms are fundamentally uncertain, most, fortunately, just disappear but they can also become indicators of major illness and death: the patient could have developed chest pain, for instance. To be able to deal with inevitable uncertainties, good medicine makes room for the general, for the discussion, although that might sometimes be at the expense of the particular. Fragmentation may seem to be winning, but GPs can help us, as persons, to integrate and not get lost in the medical swamps.

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## References

1. Abbt N, Alderson S. Why doesn't anyone want to be a GP: and what can we do about it? 2014 2014-11-01(64):579. en.
2. The Kings Fund. Improving the quality of care in general practice. Independent inquiry into the quality of care in general practice in England (pp. 1-169). . @TheKingsFund, 2011 2011-03-24. Report No.
3. Charles-Jones H, Latimer J, May C. Transforming general practice: the redistribution of medical work in primary care. *Sociology of health & illness*. 2003 Jan;25(1):71-92. PubMed PMID: 14498945. Epub 2003/09/23. eng.
4. Gadamer H. *Truth and Method*. London: Bloomsbury Academic; 2018 2013.
5. Marchand C, Peckham S. Addressing the crisis of GP recruitment and retention: a systematic review. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2017 Apr;67(657):e227-e37. PubMed PMID: 28289014. Pubmed Central PMCID: PMC5565821. Epub 2017/03/16. eng.
6. Verma P, Ford JA, Stuart A, Howe A, Everington S, Steel N. A systematic review of strategies to recruit and retain primary care doctors. *BMC health services research*. 2016 Apr 12;16:126. PubMed PMID: 27067255. Pubmed Central PMCID: PMC4828812. Epub 2016/04/14. eng.
7. Croxson CH, Ashdown HF, Hobbs FR. GPs' perceptions of workload in England: a qualitative interview study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2017 Feb;67(655):e138-e47. PubMed PMID: 28093422. Pubmed Central PMCID: PMC5308120. Epub 2017/01/18. eng.
8. Riley R, Spiers J, Buszewicz M, Taylor AK, Thornton G, Chew-Graham CA. What are the sources of stress and distress for general practitioners working in England? A qualitative study. *BMJ Open*. 2018 Jan 11;8(1):e017361. PubMed PMID: 29326181. Pubmed Central PMCID: PMC5780684. Epub 2018/01/13. eng.
9. Danczak A, Lea A, Murphy G. *Mapping Uncertainty in Medicine*. London, UK: Royal College of General Practitioners; 2016. 1-332 p.
10. Buckman L. Changes to the GP contract threaten general practice in the UK. 2012 2012-10-31. en.
11. Lamberts H, Hofmans-Okkes IM. [Psychological and social problems in family practice: a matter of competence and autonomy in physicians and patients]. *Ned Tijdschr Geneesk*. 1994;138:118-22.
12. Matheson C, Robertson HD, Elliott AM, Iversen L, Murchie P. Resilience of primary healthcare professionals working in challenging environments: a focus group study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2016 Jul;66(648):e507-15. PubMed PMID: 27162205. Pubmed Central PMCID: PMC4917054. Epub 2016/05/11. eng.
13. Heneghan C, Glasziou P, Thompson M, Rose P, Balla J, Lasserson D, et al. Diagnostic strategies used in primary care. *BMJ*. 2009 Apr 20;338:b946. PubMed PMID: 19380414. Pubmed Central PMCID: PMC3266845. Epub 2009/04/22. en.
14. Stewart M, Brown JB, Weston WW, McWhinney IR, Freeman TR. *Patient-centered medicine, transforming the clinical method* (2nd edition). Oxford: Radcliffe; 2003.
15. Gawande A. *Being Mortal*. London: Profile Books Ltd.; 2014 2014. 0-304 p.
16. Arie S. Why are Dutch GPs so much happier? 2015 2015-12-29. en.
17. Widdershoven GA. Care, cure and interpersonal understanding. *Journal of advanced nursing*. 1999 May;29(5):1163-9. PubMed PMID: 10320500. Epub 1999/05/13. eng.

18. Hobbs FDR, Bankhead C, Mukhtar T, Stevens S, Perera-Salazar R, Holt T, et al. Clinical workload in UK primary care: a retrospective analysis of 100 million consultations in England, 2007–14. *The Lancet*. 2016;387:2323-30. PubMed PMID: 27059888.
19. Maarsingh OR, Henry Y, van de Ven PM, Deeg DJ. Continuity of care in primary care and association with survival in older people: a 17-year prospective cohort study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2016 Aug;66(649):e531-9. PubMed PMID: 27324627. Pubmed Central PMCID: PMC4979943. Epub 2016/06/22. eng.
20. Lamberts H, Wood M. *ICPC: International Classification of Primary Care*. Oxford: Oxford University Press; 1987. 204 p.
21. Soler JK, Okkes I, Wood M, Lamberts H. The coming of age of ICPC: celebrating the 21st birthday of the International Classification of Primary Care. *Family practice*. 2008 Aug;25(4):312-7. PubMed PMID: 18562335. Epub 2008/06/20. eng.
22. Stadje R, Dornieden K, Baum E, Becker A, Biroga T, Bosner S, et al. The differential diagnosis of tiredness: a systematic review. *BMC family practice*. 2016;17:147. PubMed PMID: 27765009.
23. Kenter EGH, Okkes IM, Oskam SK, Lamberts H. Once tired, always tired? Limitations in function over time of tired patients in Dutch general practice. *The European journal of general practice*. 2007;13:67-74. PubMed PMID: 17534742.
24. Kenter EGH, Okkes IM, Oskam SK, Lamberts H. Tiredness in Dutch family practice. Data on patients complaining of and/or diagnosed with "tiredness". *Family practice*. 2003;20:434-40. PubMed PMID: 12876117.
25. Armstrong D. Diagnosis and nosology in primary care. *Social Science and Medicine*. 2011;73:801-7. PubMed PMID: 21669483.
26. Gillam S. George Man Burrows and the anguished birth of general practice. *BMJ (Clinical research ed)*. 2017;359:j5713. PubMed PMID: 29242194.
27. Dale J, Potter R, Owen K, Parsons N, Realpe A, Leach J. Retaining the general practitioner workforce in England: what matters to GPs? A cross-sectional study. *BMC family practice*. 2015;16:140. PubMed PMID: 26475707.
28. Fisher RF, Croxson CH, Ashdown HF, Hobbs FR. GP views on strategies to cope with increasing workload: a qualitative interview study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2017 Feb;67(655):e148-e56. PubMed PMID: 28093421. Pubmed Central PMCID: PMC5308121. Epub 2017/01/18. eng.
29. Harding A, Rosenthal J, Al-Seaidy M, Gray DP, McKinley RK, Society for Academic Primary Care Heads of Teaching G. Provision of medical student teaching in UK general practices: a cross-sectional questionnaire study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2015 Jun;65(635):e409-17. PubMed PMID: 26009536. Pubmed Central PMCID: PMC4439831. Epub 2015/05/27. en.
30. Dixon-Woods M, Yeung K, Bosk CL. Why is U.K. medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors. *Social science & medicine (1982)*. 2011 Nov;73(10):1452-9. PubMed PMID: 21975027. Epub 2011/10/07. eng.
31. Merrett A, Jones D, Sein K, Green T, Macleod U. Attitudes of newly qualified doctors towards a career in general practice: a qualitative focus group study. *The British journal of general practice : the journal of the Royal College of General Practitioners*. 2017 Apr;67(657):e253-e9. PubMed PMID: 28360072. Pubmed Central PMCID: PMC5565810. Epub 2017/04/01. eng.
32. Jones L, Green J. Shifting discourses of professionalism: a case study of general practitioners in the United Kingdom. *Sociology of health & illness*. 2006 Nov;28(7):927-50. PubMed PMID: 17163860. Epub 2006/12/14. eng.
33. Kontopantelis E, Mamas MA, van Marwijk H, Ryan AM, Bower P, Guthrie B, et al. Chronic morbidity, deprivation and primary medical care spending in England in 2015-16: a cross-sectional

spatial analysis. BMC medicine. 2018 Feb 14;16(1):19. PubMed PMID: 29439705. Pubmed Central PMCID: PMC5812046. Epub 2018/02/15. eng.

34. Beck U. Risk Society: Towards a New Modernity London: Sage Publications Ltd.; 1992 2018-01-19.

35. Ham C. Health Policy in Britain. 6th Edition. . London: Palgrave; 2009.